- Case Home
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- Voluntary Petition
- Bankruptcy Industry Links
- Disclaimer

City of Detroit, Michigan

Case Number:

13-53846

- Case Home
-

- Case Home
- Proof Of Claim Form
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Claim Search Results

Filter applied: Debtor(s): All Debtors Claim Amount Type: Filed Claim Amount Claim #: 1097

- **Claim Number:** 1097

Name: Richard Hall

Filed Claim Amount: $1,000,000.00

Date Claim Filed: 2/18/2014

Debtor: City of Detroit, Michigan

Filed Claim Nature: General Unsecured

B10 (Official Form 10) (04/13) (Modified)

UNITED STATES BANKRUPTCY COURT EASTERN DISTRICT of MICHIGAN	CHAPTER 9 PROOF OF CLAIM
Name of Debtor: City of Detroit, Michigan — Case Number: 13-53846	
NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing.*	
Name of Creditor (the person or other entity to whom the debtor owes money or property): Richard Hall	COURT USE ONLY
Name and address where notices should be sent: Richard Hall, 3752 Eastern Place, Detroit, MI 48208. Telephone number: 330-831-3346 email:	☐ Check this box if this claim amends a previously filed claim. Court Claim Number: _____ (If known) Filed on: _____
Name and address where payment should be sent (if different from above): Telephone number: email:	☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. Amount of Claim as of Date Case Filed: $ 1,000,000.00

If all or part of the claim is secured, complete item 4.
If all or part of the claim is entitled to priority, complete item 5.
☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: (See instruction #2) False Arrest, excessive force, pursuant to 42 USC 1983 (or wrongful detention), assault & battery, false imprisonment under Michigan law

3. Last four digits of any number by which creditor identifies debtor:

3a. Debtor may have scheduled account as: (See instruction #3a)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: $_____

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Basis for perfection: _____

Value of Property: $_____

Amount of Secured Claim: $_____

Annual Interest Rate (when case was filed) _____ % ☐ Fixed or ☐ Variable

Amount Unsecured: $_____

5. Amount of Claim Entitled to Priority as an Administrative Expense under 11 U.S.C. §§ 503(b)(9) and 507(a)(2). $_____

5b. Amount of Claim Otherwise Entitled to Priority. Specify Applicable Section of 11 U.S.C. § _____. $_____

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

7. Documents: Attached are redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and redacted copies of documents providing evidence of perfection of a security interest are attached. *(See instruction #7, and the definition of "redacted".)* DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.
If the documents are not available, please explain:

8. Signature: (See instruction # 8)
Check the appropriate box.

☒ I am the creditor ☐ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Richard Hall
Title: _____
Company: _____
Address and telephone number (if different from notice address above): _____

Richard Hall
(Signature) (Date)

Telephone number: email:

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

I was Myself nor Attorney had/or ever received a Response. My Line-up was cancelled Person. EM. To A FOIA since Jan 2012.

I do not have an Attorney at this time / FOIA was not responded to: so I had no grounds to file suit. but instead a claim during Bankruptcy proceedings courts

This is an informal letter to the objection to my claim of My Stated Basis: "False arrest, excessive force pursuant to 42 U.S.C. 1983 (or wrongful detention) assault and battery, false imprisonment under Michigan law".

Incident Occured ~~10-28-14~~ 10-28-11

Claim #1097 $1,000,000.00 Amount of Claim - submitted to courts Feb 18, 2014 within Time limits

Statue of Limitations

There is no statue of limitations contained within the language of 42 USC § 1983. The United States Supreme Court has directed that 42 USC § 1988 "requires courts to borrow and apply to all § 1953 claims the "most analogous state statute of limitations." Owens v Okure, 488 US 235, 240 (1989). Thus, for tort based actions brought in Michigan under § 1983, the appropriate Statue of Limitations is 3 years, pursuant to MCL 600.5805 (10). M

The Michigan tolling statue is consistent with §1983's remedial purpose

My claim was accepted by court Filing deadlines of Feb 21, 2014 long before Oct 28, 2014 Statue of Limitations that Court Acts basing Expired limitation concerni

Federal Rules of Bankruptcy Procedure

Distribution to creditors and Equity Interest holders; Plans Rule 3007. Objections to claim (a) Objections to Claims. An objection to the allowance of a claim shall be in writing and filed. A copy of the objection with Notice of the hearing thereon shall be mailed or otherwise delivered to the claimant, the debtor or debtor in possession, and the trustee at least 30 days prior to the hearing. I have neither been served in a timely fashion of the courts objections. this was filed 3-27-15 and I received in Mail 4-1-2015

MCL 600.5805 Injuries to persons or property; period of limitations; "dating relationship" defined.

Sec. 5805

~~(1)~~ (1) A person shall not bring or maintain an action to recover damages for injuries to persons or property unless, after the claim first ~~accrued~~ accrued to the plaintiff or to someone through whom the plaintiff claims, the action is commenced within the periods of time prescribed by ~~this~~ section.

(2) Subject to subsections (3) and (4), the period of limitations is 2 years for an action charging assault, battery, or false imprisonment.

(3) The period of limitations is 5 years for an action charging assault or battery brought by a person who has been assaulted or battered by his or her spouse or former spouse, an individual with whom he or she has had a child in common, or a person with whom he or she resides or formerly resided.

(4) The period of limitations is 5 years for an action charging assault and battery brought by a person who has been assaulted or battered by an individual with whom he or she has or has had a dating relationship.

(10) Except as otherwise provided in this section, the period of limitations is 3 years after the time of the death or injury for all actions to recover damages based on the death, or for the injury to a person or property.

(b) Demand for Relief Requiring an Adversary Proceeding. A party in interest shall not include a demand for relief of a kind specified in Rule 7001 in an objection to the allowance of a claim, but may include the objection in an adversary proceeding.

Rule 7001

Paragraph (4) of the rule is amended to create an exception for objections to discharge under §§ 727(a)(8), (a)(9), and 1328(f) of the code. Because objections to discharge on these grounds typically present issues more easily resolved than other objections to discharge, the more formal procedures applicable to adversary proceedings, such as commencement by a complaint, are not required. Instead, objections on these three grounds are governed by Rule 4004(d). In an appropriate case, however, Rule 9014(c) allows the court to order that additional provisions of Part ~~VII~~ of the rules apply to these matters

The proposed addition of subsection (b) was deleted, and the content of that provision was moved to Rule 4004(d). The exception in paragraph (4) of the rule was revised to refer to objections to discharge under §§ 727(a)(8), (a)(9), and 1328(f) of the Code. The redesignation of the existing ~~rules~~ rule as subdivision (a)(9) was also deleted. The Committee Note was revised to reflect these changes.

PHYSICIAN DOCUMENTATION SHEET
Sun Nov 13 08:01:23 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Assault
Arrival Time: 10/29/2011 03:44
Account #: 1302
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Nasal Fracture
Discharge Time: 10/29/2011 07:54
All Providers: MD Mayura Phadtare; MD EM Staff Stephanie Stokes-Buzzelli

HPI:

The patient is a 35-year-old male who presents with a chief complaint of assault. The history was provided by the patient. Patient reports with assaukIted with fists to face, back of head and chest by individuals just prior to ED arrival. Reports pain at back of head and right side of chest wall. Denies LOC, nausea/vomiting, or shortness of breath. Patient with recent right shoulder dislocation with shoulder in sling however denies any pain or new injury to shoulder at this time. The initial case discussion and decision making with stokes-Buzzelli, Stephanie - Emergency Medicine.

11:04 10/29/2011 by Mayura Phadtare, MD

ROS:

Constitutional: Negative for fever and chills.

07:07 10/29/2011 by Mayura Phadtare, MD

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: none
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

07:07 10/29/2011 by Mayura Phadtare, MD

Home Medications:

Henry Ford Health System **Office Note**

Document State: Final (version 3)
Update Date/Time: 02/08/2012 09:49

Patient Name: **HALL, RICHARD L.**
DOB/Age/Gender: 11/11/1975 36y Male
Location: HF,HF Medical Center-Detroit Campus Clinic Neurology (K-11)

MRN: **HF 33680716**

Service Date/Time: 02/06/2012 00:00
Provider: KOMAL H ASHRAF MD
Responsible Staff: IRAM F ZAMAN DO

CHIEF COMPLAINT
Headaches.

HPI
The patient is a 36-year-old right-handed male, who presents to the neurology clinic for the first time with complaints of bilateral temporoparietal "banging" headache. The patient reports that the headache began in April of 2011 and has been every day all day. He reports that the pain is 10/10 on a pain scale daily. He does not recall the last time that he was pain free. He does report photophobia and phonophobia as well as nausea. He denies any vomiting, numbness, tingling, weakness, or vision problems.

The patient reports that he also feels like his memory has decreased. He states that last year he had a few occasions of head injury and stress including a motor vehicle accident in which he was a passenger and suffered dizziness and minor head trauma at the time. In addition, he was assaulted twice per his report, once by a friend, and once by the police. He reports that since then, his memory has been 30% of what it used to be and he reports that "before my memory was very sharp." He reports that he has difficulty spelling simple words and has lost some moments in time and has difficulty with some recollection. He reports that there were approximately 10 to 20 spells within the last year that he has "lost memory." The patient does report that he has some pain and stiffness from the top of his neck radiating to the back of his head. He reports that this has become more significant from 1 of the assaults last year. During one of these episodes, he also reports bruising/injury to a few ribs as well as a concussion, and a broken nose, which he just got repaired yesterday. The patient reports that he has not tried anything for his headache. He has recently been given a prescription for Vicodin due to his nose surgery, but has not taken that to assess whether he would find relief for his headache. He also reports that he has had some difficulty sleeping. He has lost some interest in things that he used to do. He reports that he has loss of appetite and does not feel like eating very much and has difficulty with concentrating on tasks. He denies being suicidal or homicidal ideations. The patient reports that the headaches and the memory have become worse since the car accident and reported assaults.

REVIEW OF SYSTEMS
A 14-system review was completed with the following abnormalities: Migraine, memory loss, trouble thinking, and sleep problems. All other systems were reviewed and negative.

FAMILY MEDICAL HISTORY
Significant for his dad, who has migraine headache. All else is negative including MS, stroke, autoimmune problems.

SOCIAL HISTORY
The patient reports that he has completed his GED and a couple semesters of college. He is currently not working, however, does report that he had a job as a 'physician's assistant' in the past. This sounds questionable, however, because more schooling

is 5/5 in all four extremities.

SENSORY EXAMINATION
Sensory examination is intact to light touch.

REFLEXES
Reflexes are 2/4 and symmetrical in all four extremities. Plantar response is flexor bilaterally.

COORDINATION
Fine coordinated movements are performed well bilaterally.

GAIT AND STATION
Gait is normal. Romberg is negative.

LABS AND IMAGING
The patient had an MRI of his right shoulder due to dislocation on January 23rd, 2012, which was consistent with that as well as a fibrocartilaginous labral tear on the right. His rotator cuff was intact. CT C-spine and maxillofacial were done on August 31st, 2011, likely after an episode of being assaulted, which demonstrated mild degenerative changes at the C-spine at level C4 through C7.

ASSESSMENT AND PLAN
This is a 36-year-old male, who presents with bilateral temporoparietal headache that has been ongoing and daily for approximately a year as well as episodes of "losing time" in the setting of a normal neurological physical examination.

1. Headaches. These are likely new daily persistent headache, of migrainus or tension type. He does have features of migraine with the photophobia and phonophobia as well as nausea; however, the bilateral nature is more fitting with tension. It is recommended that the patient take daily amitriptyline, we will start at a low dose and increase in a month's time if he tolerates it. Side effects, risks/benefits were reviewed with the patient. Due to the report of neck pain and tenderness along the musculature, physical and occupational therapy will be recommended as this may assist in pain relief.

2. Memory loss. It is not suspected that the patient is suffering from epileptic events; however, in order to be sure, an EEG will be obtained. Due to his past traumatic events and change in mood and interest as well as reported sleep difficulties, it was recommended that he see and obtain therapy at behavioral health. The patient declined this and reported that he is not interested in counseling, psychiatric consultation, or behavioral therapy. It was explained to him that often times, depression or anxiety may manifest itself as difficulty with memory and sleep deficits; he was also told that headaches are common in such scenarios. The patient was encouraged that should he change his mind and like to obtain referral for this, to call our clinic and this can be arranged.

Follow up is recommended in 3 to 4 months, at which time we will review his EEG results and determine how the amitriptyline is working. It was recommended that he call in a month's time to discuss amitriptyline whether we should increase it. He was encouraged to call the clinic for any questions or concerns in the interim. The patient verbalized agreement and understanding of the included assessment and plan and follow up

PHYSICIAN DOCUMENTATION SHEET

Tue May 01 08:00:51 EDT 2012

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint: Rib pain
Arrival Time: 04/16/2012 20:30
Account #: 2107
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 04/16/2012 23:40
All Providers: MD Vinod Kumar; MD EM Staff Jumana Nagarwala

HPI:

The patient is a 36-year-old male who presents with a chief complaint of rib pain. The history was provided by the patient and CarePlus review. Patient says he was assaulted by the police in October 2011 and sustained broken ribs on the R chest and injuries to his R wrist. He has been having pain in the R chest and ribs ever since then. He was running away from dogs 4 days ago, jumped over a fence, and landed on the R chest. He denies SOB or pleuritic chest pain but is afraid that he reinjured his ribs. He has also been punched different objects with his R hand for the past few weeks and is concerned that he has reinjured the R wrist. Careplus review shows that in 2011 he had 2 stae flexor tendon rpair of R ring and middle finger, and clinic notes show that he had soft tissue swelling over the R wrist at that time. Patient asking for prescription for pain meds. The rib pain occurred several months ago. The mechanism of injury was a(n)assaulted. Localized symptoms include pain . The initial case discussion and decision making with nagarwala, Jumana - Emergency Medicine.

01:37 04/17/2012 by Vinod Kumar, MD

ROS:

Constitutional: Negative for fever.
Eyes: Negative for visual change.
ENMT: Negative for sore throat.
Cardiovascular: Negative for chest pain.
Respiratory: Negative for shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea and abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for joint pain, joint swelling and arthralgias.
Skin: Negative for rash.
Neuro: Negative for headache and abnormal gait.
Psychiatric: Negative for behavior change.
Metabolic: Negative for excessive thirst.
Hematologic: Negative for anemia.
Allergic: Negative for rash.

01:36 04/17/2012 by Vinod Kumar, MD

PMH:

Reviewed by: physician

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date	Date of Accident	File Number
	Oct 29 2011	
Applicant's Name Richard L. Hall	Home Phone Number	Business Phone Number 330 831 3346
Address 3752 Eastern Place Detroit MI 48208	Date of Birth 11-11-75	Social Security No. 385-66 7987
Date & Time of Accident (am/pm)	Place of Incident (Exact Location) Dexter and Blvd	on the front left yard of New Center Comm Health Mental

Brief Description of Accident:
Kneed in Nose by short Caucasian officer / Kicked in Ribs by Tall African American officer and Heavy set Caucasian officer Layed on back while Assaulted

As a result of the incident were you injured? ☒Yes ☐No If yes, please complete the rest of this form.

Describe your injury
Broken Nose / broken 8th and 9th Right Ribs

Were you treated in a Hospital? ☒Yes ☐ No If yes, please list Hospitals Name and Address.
Henry Ford Main Campus / E.R. 2799 W. Grand Blvd.

Did a Doctor treat you? ☒Yes ☐ No If yes, please list Doctor's Name and Address.
E.R. Doctors / Dr Jones E.N.T Unit Ears Nose Throat Surgery - Henry Ford

I, THE UNDERSIGNED, HEREBY AUTHORIZE ANY PHYSICIAN OR NURSE WHO ATTENDED THE ABOVE NAMED, OR ANY HOSPITAL AT WHICH ABOVE NAMED HAS BEEN CONFINED, TO FURNISH THE CITY OF DETROIT LAW DEPARTMENT, WITH ANY AND ALL INFORMATION WHICH MAY BE REQUESTED REGARDING PAST PHYSICAL CONDITION AND TREATMENT RENDERED AND TO ALLOW THEM OR ANY PHYSICIAN APPOINTED BY THEM TO EXAMINE AND COPY ANY AND ALL RECORDS WHICH YOU MAY HAVE REGARDING CONDITION OR TREATMENT, INCLUDING ALCOHOL AND DRUG PART 2, IF ANY; PSYCHOLOGICAL SERVICES AND SOCIAL SERVICES RECORDS INCLUDING COMMUNICATIONS MADE TO A SOCIAL WORKER OR PSYCHOLOGIST OR PSYCHIATRIST, IF ANY; RECORDS OF COMMUNICABLE DISEASES AND SERIOUS COMMUNICABLE DISEASES AND INFECTIONS, VENEREAL DISEASE (VD), TUBERCULOSIS (TB), HEPATITIS B, HUMAN IMMUNODEFICIENCY VIRUS (HIV), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC), IF ANY. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE ISSUER OF THE MEDICAL RELEASE. YOUR PROTECTED HEALTH INFORMATION WILL BE DISCLOSED TO ANY AGENCY INVOLVED IN THE INVESTIGATION, EVALUATION AND RESOLUTION OF YOUR MATTER AS IT RELATES TO THE CITY OF DETROIT.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER SUBJECT TO PRIVACY PROTECTION PROVIDED BY LAW.

X Richard Hall
NAME (Signature) _____ DATE

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH

Subscribed and sworn to before me this

_____ day of _____, 2013.

_____
Notary Public, Wayne County, Michigan My Commission Expires: _____

{G:\DOCS\CLAIMS\taylr\99\form\RT4948.DOC}

MEDICARE REPORTING AFFIDAVIT AND INDEMNIFICATION OF THE CITY OF DETROIT BY THE CLAIMANT/PLAINTIFF

Richard Hall, **being first duly sworn, deposes and says that I have filed a claim and/or lawsuit against the City of Detroit:**

1. I certify under penalty of law that this Affidavit and all attachments were prepared with my knowledge and were reviewed by me. The information submitted is, to the best of my knowledge and belief, true, accurate and complete. I am aware that there are significant penalties for submitting false information, including the possibility of a fine and/or imprisonment for known violations. **I hereby state under oath and subject to any penalties for perjury that the information contained in this Affidavit is true, correct and accurate.**

2. I hereby understand that the City of Detroit will be relying upon this information in order to provide all of the required information to the United States Government, Department of Health and Human Services, Center for Medicare and Medicaid Services or their Medicare contractor in accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 and to be in compliance with the Medicare Secondary Payer Laws.

Circle One

3. I am currently receiving Medicare Benefits..... yes or (no)
4. I will be Sixty Five years old within three years..... yes or (no)
4a. I have applied for Social Security Disability Benefits..... yes or (no)
5. I have received a Social Security Disability Award Letter and attached a copy hereto.....yes or (no)
6. Attached is a copy of my Social Security Disability Application.....yes or (no)
7. Attached is a copy of my Social Security denial letter and my appeal of said denial..... yes or (no)

Circle One

17. Has anyone ever prepared for you:

a. A Life Care Plan..... yes or (no)

b. Medicare Set Aside Cost Projections .....yes or (no)

c. Life expectancy projection .....yes or (no)

If yes to any questions above in #17, submit a copy to the City of Detroit.

18. What specific body parts were impacted by the Injury/illness:

Fractured NASAL

8 and 9 Right Ribs.

19. That my Gender is: ✓ Male _____ Female

20. That the accident which gave rise to this Claim/Lawsuit occurred on:

Oct 29, 2011 (Date)

21. On _____ (Date), a Settlement or Judgement of my Claim/Lawsuit was agreed to/rendered for the total amount of _____ Dollars ($_____).

22. On the date of the accident/event, did any household family member own an automobile with valid No Fault Insurance coverage.....yes or (no)

This Medicare Reporting Affidavit and Indemnification was acknowledged, subscribed and sworn to before me this _____ day of _____, 2012, by _____, who hereby declares under penalty of perjury under the laws of the State of Michigan that he or she is authorized in fact and law to execute this Medicare Reporting Affidavit and Indemnification.

_____

Notary Public, County of _____, State of _____

My Commission Expires: _____

NOTE: SHOULD THIS RELEASE BE SIGNED BY THE CLAIMANT/PLAINTIFF OUTSIDE OF THE STATE OF MICHIGAN THAT FACT MUST BE NOTED IN THE APPROPRIATE AREA ABOVE AND THE OUT OF STATE NOTARY MUST ATTACH A CERTIFICATE OF NOTARIAL AUTHORITY FROM THE STATE HE OR SHE IS AUTHORIZED TO ACT AS A NOTARY.

3752 Easton Pl. V
D.O. [redacted] 4/8/08

Detroit Department Police

CITIZEN COMPLAINT REPORT

Report # 48535

Complainant:	*Date of Incident:*	*Date of Report:*
Richard Louis Hall	10/29/11	12/2/11

Complainant stated on 10/29/2011 at the above time and location. He was almost struck by a unmarked Detroit Police vehicle. Complainant fell from his bike and was approached by officers in vehicle. Complainant described officers as (1) white male, ball head, approx. age 30-40, 5'[7 or 9"], heavy build, (2) white male, age 45, 6'2", heavy build and (3) black male, age 30-40, 6'3", 240 lbs. All in plain clothes by officer with badge around neck. Complainant further stated that white officer placed his knee on complainant's back. The short white officer used his knee to hit Complainant's face and the black officer kicked Complainant on right side. A white marked Detroit police responded to location but was waved off by plain closed officers. The officers stated they were looking for guns. The short white officer pulled out a backup gun saying it belongs to Compl. The Complainant left the scene and was treated at the hospital for a broke nose and ribs. Notified Internal Affairs. Sgt. Roche advised make CCR and fax copy.

ATTN: 313 596 2440
CAPTAIN Rasheed

CITY OF DETROIT
POLICE DEPARTMENT

1300 BEAUBIEN, SUITE 303
DETROIT, MICHIGAN 48226
PHONE: 313·596·1800
WWW.DETROITMI.GOV

April 6, 2012

Mr. Richard Hall

Re: Force Investigation Case 12-009

Dear Mr. Hall

The Detroit Police Department is committed to providing professional service. I scheduled you for appointment on April 6, 2012, at 1:00 P.M. However, due to the current state of the city and the necessity to be available for any possible civil disturbance, the interview must be postponed. You a re tentatively scheduled for April 11, 2012, at 2:00PM. If this information changes you be notified.

Please call me at (313) 596-2424, Monday through Friday 8:00 a.m. to 4:00 p.m., if you have any questions or concerns.

Sincerely,

Tonyua Roche

TONIQUA ROCHE
Sergeant, S-959
Force Investigation

This was Day of Line-up. It was never Rescheduled.

CITY OF DETROIT
LAW DEPARTMENT

COLEMAN A. YOUNG MUNICIPAL CENTER
2 WOODWARD AVENUE, SUITE 500
DETROIT, MICHIGAN 48226-3535
PHONE 313•224•4550
FAX 313•224•5505
WWW.DETROITMI.GOV

December 11, 2013

Richard Louis Hall
6433 Vinewood Street
Detroit, MI 48208

RE: Freedom of Information Act Request Dated May 15, 2013 Concerning Detroit Police Department (DPD) Records Pertaining to an Incident on October 29, 2011 Involving Richard Louis Hall

Dear Mr. Hall:

This letter serves as the City of Detroit's response to the above-referenced matter. Your request was received at the City of Detroit Law Department Governmental Affairs Section Freedom of Information Division on May 15, 2013. Thank you for your patience in this matter.

Your requests seek:

"4.	Type of record requested:	FOIA Internal Affairs Sgt. Roche at 313-596-2424 My Assault was under investigation by Sgt. Roche
5.	Name referred to in record:	Richard Louis Hall
6.	Type of incident, if any:	Assault & Battery on Oct. 29, 2011
7.	Date and time of incident, if any:	Oct. 29, 2011
8.	Detroit address or intersection of incident, if any:	W. Grand Blvd & Dexter"

As to any Internal Affairs investigation records, your request is denied pursuant to Section 13(1)(d), (m), and (s)(ix) of the Act, MCL 15.243(1)(d), (m) and (s)(ix), and Section 9(2) of the Michigan Bullard-Plawecki Employee Right-to-Know Act, MCL 423.509(2). Based on information provided by Detroit Police Department (DPD) personnel, it is our understanding that disciplinary actions against police officers are maintained separately by the DPD in accordance with MCL 423.509(2). Therefore, the release of such information would result in the violation of Michigan Bullard-Plawecki Employee Right-to-Know Act. As such, records of an internal investigation of police misconduct are exempt from disclosure. See also, Sutton v City of Oak Park, 251 Mich App 345; 650 NW2d 404 (2002).

Moreover, the release of the DPD Internal Affairs investigative records would create a chilling effect, and may result in intimidation or harassment of the complainant or the witnesses.

Therefore, the release of such record would do more harm than good for the public, as fewer individuals, including fellow police officers, would likely report police misconduct for fear of reprisal or retaliation. See, Newark Morning Ledger Co v Saginaw County Sheriff, 204 Mich App 215; 514 NW2d 213 (1994). Further, release of certain statements would violate Garrity rights of the police officers. Garrity v New Jersey, 385 US 493; 87 S Ct 616; 17 L Ed 562 (1967)

DPD did provide a copy of the Findings letter and to the extent this record corresponds to your request, your request is granted

The record from the Detroit Police Department consists of one (1) page. Enclosed please find one (1) copy of same. Because the enclosed record comprises fewer than ten (10) pages, no copying costs have been assessed.

Please be advised that, pursuant to Section 10 of the Michigan Freedom of Information Act, being MCL 15.240, a person receiving a written denial of a request may do one of the following:

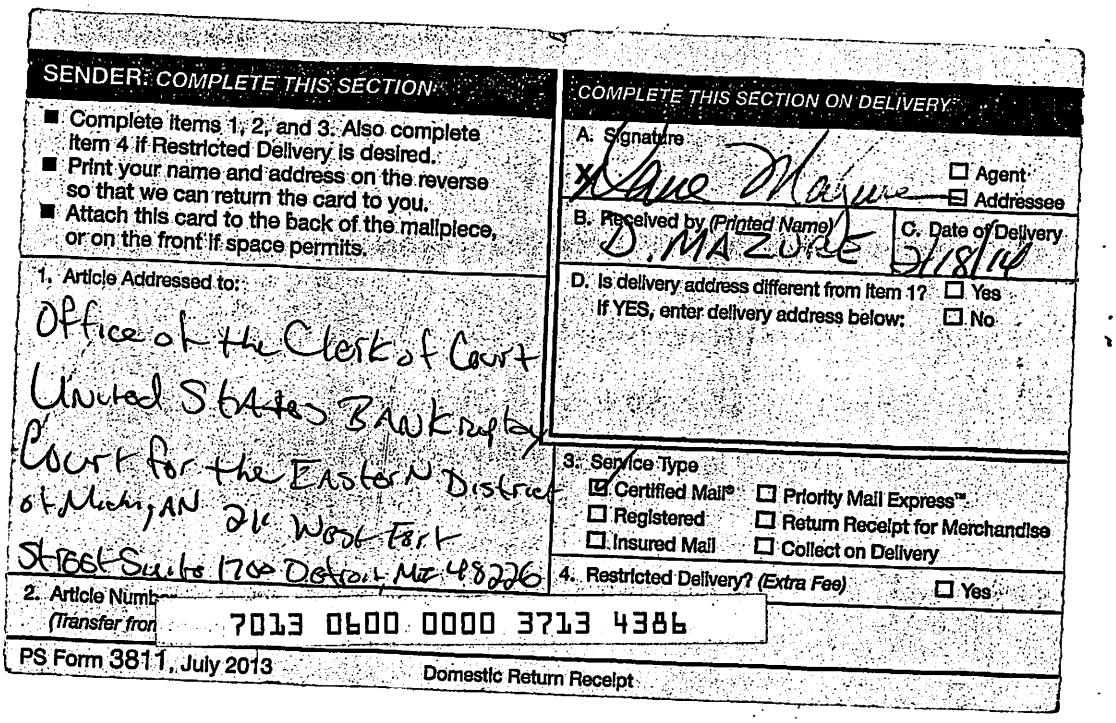
1) Submit a written appeal to the head of the public body denying the request. Such appeal, if submitted, should specifically state the word "appeal" and identify the reason or reasons for reversal of the denial. MCL 15.240(1)(a); or

2) Commence an action in the circuit court to compel the disclosure of the public records within 180 days after the public body's denial of the request. MCL 15.240(1)(b). If a court finds that the information withheld by a public body is not exempt from disclosure, the requesting party may receive the requested record and, at the discretion of the court, reasonable attorney fees and /or costs. MCL 15.240(6) and (7).

Very truly yours,

Jack F. Dietrich
Assistant Corporation Counsel
Freedom of Information Section
(313) 237-5030

JD/



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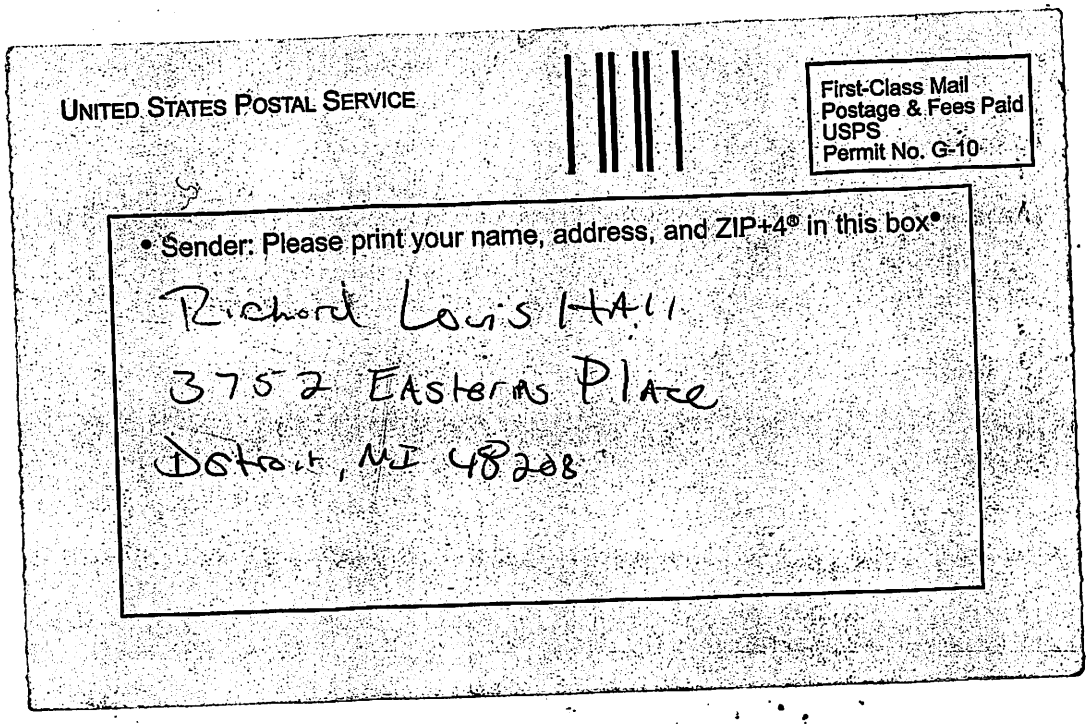
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Richard Louis Hall
3752 Eastern Place
Detroit, MI 48208

PHYSICIAN DOCUMENTATION SHEET
Sun Nov 13 08:01:23 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Assault
Arrival Time: 10/29/2011 03:44
Account #: 1302
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Nasal Fracture
Discharge Time: 10/29/2011 07:54
All Providers: MD Mayura Phadtare; MD EM Staff Stephanie Stokes-Buzzelli

HPI:

The patient is a 35-year-old male who presents with a chief complaint of assault. The history was provided by the patient. Patient reports with assauklted with fists to face, back of head and chest by individuals just prior to ED arrival. Reports pain at back of head and right side of chest wall. Denies LOC, nausea/vomiting, or shortness of breath. Patient with recent right shoulder dislocation with shoulder in sling however denies any pain or new injury to shoulder at this time. The initial case discussion and decision making with stokes-Buzzelli, Stephanie - Emergency Medicine.

11:04 10/29/2011 by Mayura Phadtare, MD

ROS:

Constitutional: Negative for fever and chills.

07:07 10/29/2011 by Mayura Phadtare, MD

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: none
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

07:07 10/29/2011 by Mayura Phadtare, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
07:07 10/29/2011 by Mayura Phadtare, MD

Physical examination:

Vital Signs: vital signs per nurses
Constitutional: alert, awake, comfortable appearance
O/E - head - general examn.: no bony depressions or step offs of skull NOTE - small hematoma on posterior aspect of scalp on left

Eyes: conjunctivae and lid normal, EOMI
ENMT: mouth and pharynx normal, dried blood in nares
Neck: supple, non-tender
Cardiovascular: regular rate and rhythm, NL S1/S2
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal, skin color good
Neuro: A&Ox3
Extremity Exam: normal appearance, No pedal edema
NOTE - nasal septum appears displaces with mild overlying edema
07:07 10/29/2011 by Mayura Phadtare, MD

Medical Decision Making:

Differential Diagnosis: contusion, fracture
Diagnostic Evaluation: xrays
Impressions: Will get xray of chest and nose to evaluate for fracture. Will not get CT due to mechanism, no LOC and unremarkable neurological or bony findings.
Amount and complexity of data: discussion with family
07:07 10/29/2011 by Mayura Phadtare, MD

Reassessment:

Reassessment of symptoms: improved
Radiographs reviewed: see radiograph report
Observations: remains awake and alert.
Reassessment: Possible small nondisplaced nasal fx. Will d/c home.
08:07 10/29/2011 by Mayura Phadtare, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

07:07 10/29/2011 by Mayura Phadtare, MD

Patient disposition:

Primary Diagnosis: Nasal Fracture
Additional diagnoses: contusions
Patient disposition: Disch - Home
07:07 10/29/2011 by Mayura Phadtare, MD

Discharge:

Discharge Instructions:
cold therapy, nasal fracture

Append a Note to Discharge Instructions: Follow up with ENT for your nasal bone fx - call to make an appt.

Referral/Appointment			
Refer Patient To:	**Phone Number:**	**Follow-up in**	**Appointment Details:**
Ent-Main Campus/313-916-3272			

07:08 10/29/2011 by Mayura Phadtare, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Motrin 800 mg Tab	#30	1 po 3-4 times a day prn pain
VICOdin ES 7.5 mg-750 mg Tab	#10	1 PO q4hrs prn pain

07:51 10/29/2011 by Mayura Phadtare, MD

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
18:28 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

Chart electronically signed by Responsible Physician
18:29 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

Henry Ford Health System **Operative Note**

Document State: **Final** (version 2)
Update Date/Time: **09/12/2012 10:49**

Patient Name: **HALL, RICHARD L.**
DOB/Age/Gender: **11/11/1975 36y Male**
Location: **HF,HF Medical Center-Fairlane Operating Room**

MRN: **HF 33680716**

Service Date/Time: **09/10/2012 00:00**
Provider: **MATTHEW M SMITH**
Responsible Staff: **LAMONT JONES MD**

Anesthesia: General

PREPROCEDURE DIAGNOSIS: Recurrent tonsillitis

POSTPROCEDURE DIAGNOSIS: Recurrent tonsillitis

OPERATION: 1. Tonsillectomy.

SURGEON: Lamont Jones MD

ASSISTANT: Matthew Smith MD

ANESTHESIA: General

EBL: 5 ml

OPERATIVE FINDINGS: Patient had 2+ tonsils bilaterally which were equal in size.

INDICATION FOR PROCEDURE: Patient is a 36 year old male with history of recurrent tonsillitis and chronic tonsilliths who did not want to try conservative treatment and wanted his tonsils removed. He was discussed the risks and benefits of tonsillectomy and consented for the procedure.

DESCRIPTION OF PROCEDURE: After time out and under general endotracheal anesthesia, the self-retaining mouth gag was inserted, opened, and suspended on the Mayo stand. No submucous cleft palate was found on palpation.

Local anesthetic was then injected into the soft palate (10ml of 0.25% marcaine plain).

A curved Allis clamp was used to retract the right tonsil medially, and an incision along the anterior tonsillar pillar was made using electrocautery. Further dissection revealed the tonsillar capsule, and capsular dissection allowed for the complete excision of the right tonsil. Meticulous hemostasis was achieved using electrocautery. A similar procedure was completed on the left.

The mouth gag was relaxed briefly before being resuspended. The tonsillar fossae were gently abraded, and meticulous hemostasis was ensured bilaterally. An orogastric tube was passed into the stomach and suctioned out.

Then all equipment was removed and the patient was returned to anesthesia care. The patient was awoken, extubated, & returned to PACU in stable condition.

Attestation

I was present for the entire period between opening and closing of the procedure(s).

Signed by **LAMONT JONES MD** at **09/12/2012 10:49:21**.

Operative Note

Document State: Final (version 2)
Update Date/Time: 02/13/2012 11:15

Patient Name: HALL, RICHARD L.
DOB/Age/Gender: 11/11/1975 36y Male
Location: HF,HF Medical Center-Detroit Campus Clinic ENT/Audiology (K8)

MRN: HF 33680716

Service Date/Time: 02/03/2012 11:16
Provider: WILLIAM YOUNG MD
Responsible Staff: LAMONT JONES MD

Pre-Op Diagnoses:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Post-Op Diagnoses:

Anesthesia:	General
Senior Staff Physician:	JONES, LAMONT, MD
Resident:	YOUNG, WILLIAM, MD

Preop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Postop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

procedure:
1. closed septorhinoplasty
2. bilateral inferior turbinate outfracture

Surgeon: Lamont Jones, MD
Resident Surgeon: Wm. Greg Young, MD

EBL 20ml

Findings: large left septal spur and deviation of the maxillary crest. C shaped deformity of the nasal bones with the right side concave and
the left convex.

Indications: Mr. Hall is a 36 year old male with a history of nasal trauma s/p assult with nasal bone fracture and septal deformity. He complained of nasal obstruction and a recommendation was made for closed rhinoplasty with osteotomies and septoplasty with inferior tubinate outfracture. Despite the risk of bleeding, infection, septal perforation, CSF leak, smell disturbance, continued nasal obstruction, need for further procedures, and the risk of anesthesia, the patient wished to proceed.

Description:
The patient was brought to the operating room by our anesthesia colleagues where she underwent general endotracheal anesthesia. Once an adequate plane of anesthesia was achieved, the patient was prepped and draped in the usual sterile fashion. The nose was packed with Afrin-soaked pledgets. The nose was also injected with total of 6 mL of 1% lidocaine, 1:100,000 epinephrine solution. After adequate time for vasoconstriction and anesthetic effect, examation of the anterior nose with the nasal speculum revealed a large left septal spur and maxillary crest prominence. A left sided hemitransfixion incision was made and a mucoperichondrial flap was elevated on the septum and a tunnel was also elevated along the nasal floor. The two tunnels were connected at the site of the left septal spur. The bony cartilagenous junction point was separated and the deviaed bone was taken down with the open Janson middleton forceps. The small piece of septal spur was also taken down after

being completely separated from the mucoperichondreal flap.

With the spur gone, the cartilage was seen to be deviated over to the left due to the prominent maxillary crest. The cartilage was separated from the maxillary crest by incising a small stip of cartilage from its inferior aspect.

A osteotome was used to take down the deviated portion of the nasal maxillary crest. Once taken down, the attention was directed towards the nasal bones. A small pocket in the piriform aperure skin was made. The lateral osteotomes were placed against the pyriform aperature just superior to the anterior insertion of the inferior turbinate. In a high low high fashion, the osteotome was advanced through the nasal bones, first on the left then the right. The nasal bones were mobilized and directed medially with good reduction.

The hemitransfixion and priform aperature incisions were then closed in an interupted fashion with 4-0 chromic suture. A quilting suture was placed across the nasal septum. There was only a a small rent at the site of the septal spur posteriorly, without any correspoding perforation on the opposite side of the septum.

The inferior turbinates were then outractured with good results.

The stomach was suctioned with a temporary orogastric tube.

Steri-Strips and an Aquaplast cast was then applied. Patient was then awakened and extubated without difficulty.

Attestation

I was present for the entire period between opening and closing of the procedure(s).

Signed by **LAMONT JONES MD** at **02/13/2012 11:15:55**.

PHYSICIAN DOCUMENTATION SHEET
Tue Nov 29 09:33:11 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 36
Complaint: Chest injury
Arrival Time: 11/19/2011 14:58
Account #: 1323
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Rib fracture
Discharge Time: 11/19/2011 20:22
All Providers: MD EM Staff Bradley Jaskulka; MD Adam Schlichting

HPI:

The patient is a 36-year-old male who presents with a chief complaint of chest injury. The history was provided by the patient and CarePlus review. Patient with multiple complaints. He had hemrrhoid surgery here 11/17 by Dr. Lee and was perscribed vicodin 750mg and motrin 800mg but lost the perscription. He also needs dressing for his hemorrhoids, has an old right chest injury and thinks he has cracked ribs so is requesting a chest x ray and has chronic shoulder dislocations. He has also been having unprotected sex with multiple partnets, so he wanted to be "checked". He denies discharge and has not had "carnal STDs" since the 1990s; he is checked frequently he states. No fevers, no chills, no abdomen pain. The initial case discussion and decision making with jaskulka, Bradley - Emergency Medicine.

17:04 11/19/2011 by Adam Schlichting, MD

ROS:

Constitutional: Negative for fever, weakness, chills and fatigue.
Eyes: Negative for eye pain, photophobia and redness.
ENMT: Negative for ear pain, hearing loss, epistaxis and nasal congestion.
Cardiovascular: Positive for chest pain. Negative for peripheral edema and SOB on exertion .
Respiratory: Negative for productive cough and shortness of breath.
Gastrointestinal: Negative for nausea, vomiting, diarrhea, abdominal pain and constipation. NOTE - hemrrhoid surgery pain, no discaheare or redness

Genitourinary: Negative for dysuria, hematuria and polyuria.
Musculoskeletal: Negative for joint pain, joint swelling, back pain and neck pain.
Skin: Negative for rash and dry skin.
Neuro: Positive for headache and neck stiffness. Negative for abnormal gait, dizziness, lightheadedness, memory impairment, syncope and vertigo.
Psychiatric: Negative for anxiety.
Metabolic: Negative for excessive thirst, cold intolerance and hair change.
Allergic: Negative for rash.

17:04 11/19/2011 by Adam Schlichting, MD

PMH:

Reviewed by: physician

Reassessment:

Reassessment: ambulatory to clerk, asking when he can be discharged; awaiting CXR read; from my review, no major rib fracture

18:41 11/19/2011 by Adam Schlichting, MD

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.

18:41 11/19/2011 by Bradley Jaskulka, MD EM Staff

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Motrin 800 mg Tab	#30	1 po 3-4 times a day TAKE WITH FOOD for 3 days then as needed for pain
VICOdin ES 7.5 mg-750 mg Tab	15	1 tab PO Q6 hours PRN pain

19:49 11/19/2011 by Adam Schlichting, MD

Patient disposition:

Primary Diagnosis: rib fracture
Additional diagnoses: hemorrhoids, urethritis
Patient disposition: Disch - Home

19:49 11/19/2011 by Adam Schlichting, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
VICOdin Oral				continue
ibuprofen Oral				continue

19:49 11/19/2011 by Adam Schlichting, MD

Discharge:

Discharge Instructions:

hemorrhoids - without i and d, rib fracture, urethritis

Append a Note to Discharge Instructions: Follow up with Dr. Lee from surgery for refills on your pain medications. Your chest x-ray showed your 8th and 9th ribs on teh right side are broken; use pain medications to treat this pain and use the incentive spirometer every 20 minutes while awake to prevent your lungs from collapsing.

19:52 11/19/2011 by Adam Schlichting, MD

Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: hemorrhoidectomy
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

17:04 11/19/2011 by Adam Schlichting, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
VICOdin Oral		
ibuprofen Oral		

Home Medication Verification: Verified With Changes
17:04 11/19/2011 by Adam Schlichting, MD

Physical examination:
Vital Signs: vital signs per nurses
Constitutional: Oriented, Alert, in NAD, alert, awake, comfortable appearance
O/E - head - general examn.: head atraumatic, normalcephalic, face atraumatic
Eyes: conjunctivae and lid normal, EOMI, PERRL, Sclera clear, no icterus
ENMT: ear, nose and throat exam normal
Neck: supple, non-tender, no Bruit, no meningeal signs
Cardiovascular: regular rate and rhythm, NL S1/S2, no Murmurs, No JVD
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes, normal respiratory effort/excursion
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender, bowel Sounds present
Musculoskeletal: no Musculoskeletal pain, Back nontender, Joints nontender
Skin normal: capillary refill normal, warm, skin color good, skin turgor normal
Neuro: A&Ox3, motor intact in all extremities, sensation normal , normal coordination, normal speech, GCS=15, no gross CN deficits
Extremity Exam: No pedal edema
17:04 11/19/2011 by Adam Schlichting, MD

Medical Decision Making:
Differential Diagnosis: chlamydial urethritis, GC - Gonococcus infection, noncompliance with medication regimen, rib pain
Diagnostic Evaluation: CXR, GC/ chlamydia
ED monitoring: hemodynamic monitor (noninvasive), pulse oximetry monitor
Amount and complexity of data: discussion with patient, medical Records reviewed
17:04 11/19/2011 by Adam Schlichting, MD

Documentation completed by Resident
19:53 11/19/2011 by Adam Schlichting, MD

Chart electronically signed by Responsible Physician
18:44 11/20/2011 by Bradley Jaskulka, MD EM Staff

PHYSICIAN DOCUMENTATION SHEET
Sun Nov 13 08:01:23 EST 2011

Henry Ford Hospital
Emergency Department
2799 W. Grand Blvd.
Detroit, MI 48202
PHONE: (313) 916-1545

MRN: 33680716
Name: Hall, Richard L
Age: 35
Complaint: Assault
Arrival Time: 10/29/2011 03:44
Account #: 1302
Sex: M
DOB: 11/11/1975
Primary Diagnosis: Nasal Fracture
Discharge Time: 10/29/2011 07:54
All Providers: MD Mayura Phadtare; MD EM Staff Stephanie Stokes-Buzzelli

HPI:

The patient is a 35-year-old male who presents with a chief complaint of assault. The history was provided by the patient. Patient reports with assaukIted with fists to face, back of head and chest by individuals just prior to ED arrival. Reports pain at back of head and right side of chest wall. Denies LOC, nausea/vomiting, or shortness of breath. Patient with recent right shoulder dislocation with shoulder in sling however denies any pain or new injury to shoulder at this time. The initial case discussion and decision making with stokes-Buzzelli, Stephanie - Emergency Medicine.

11:04 10/29/2011 by Mayura Phadtare, MD

ROS:

Constitutional: Negative for fever and chills.

07:07 10/29/2011 by Mayura Phadtare, MD

PMH:

Reviewed by: physician
Historian: the patient, CarePlus review
Social History: non-smoker, alcohol use-none, drug use-none
Travel History: no recent foreign travel
Medical History: none
Surgical History: none
Family History: unknown
Immunization status: tetanus less than 5 years
Special Needs: no barriers to learning

Allergies		
Allergen	**Allergic reaction**	**Allergy Note**
NKDA		

07:07 10/29/2011 by Mayura Phadtare, MD

Home Medications:

Medications		
Medication	**Dosage**	**Frequency**
None		

Home Medication Verification: Verified With No Changes
07:07 10/29/2011 by Mayura Phadtare, MD

Physical examination:

Vital Signs: vital signs per nurses
Constitutional: alert, awake, comfortable appearance
O/E - head - general examn.: no bony depressions or step offs of skull NOTE - small hematoma on posterior aspect of scalp on left

Eyes: conjunctivae and lid normal, EOMI
ENMT: mouth and pharynx normal, dried blood in nares
Neck: supple, non-tender
Cardiovascular: regular rate and rhythm, NL S1/S2
Respiratory: breath sounds equal bilaterally, no rales, rhonchi, or wheezes
Chest: focal tenderness
Gastrointestinal: abdomen soft, nontender
Musculoskeletal: no Musculoskeletal pain
Skin normal: capillary refill normal, skin color good
Neuro: A&Ox3
Extremity Exam: normal appearance, No pedal edema
NOTE - nasal septum appears displaces with mild overlying edema
07:07 10/29/2011 by Mayura Phadtare, MD

Medical Decision Making:

Differential Diagnosis: contusion, fracture
Diagnostic Evaluation: xrays
Impressions: Will get xray of chest and nose to evaluate for fracture. Will not get CT due to mechanism, no LOC and unremarkable neurological or bony findings.
Amount and complexity of data: discussion with family
07:07 10/29/2011 by Mayura Phadtare, MD

Reassessment:

Reassessment of symptoms: improved
Radiographs reviewed: see radiograph report
Observations: remains awake and alert.
Reassessment: Possible small nondisplaced nasal fx. Will d/c home.
08:07 10/29/2011 by Mayura Phadtare, MD

Medication disposition:

Medications				
Medication	**Dosage**	**Frequency**	**Last Dose**	**Patient needs to:**
None				continue

07:07 10/29/2011 by Mayura Phadtare, MD

Patient disposition:

Primary Diagnosis: Nasal Fracture
Additional diagnoses: contusions
Patient disposition: Disch - Home
07:07 10/29/2011 by Mayura Phadtare, MD

Discharge:

Discharge Instructions:
cold therapy, nasal fracture

Append a Note to Discharge Instructions: Follow up with ENT for your nasal bone fx - call to make an appt.

Referral/Appointment			
Refer Patient To:	**Phone Number:**	**Follow-up in**	**Appointment Details:**
Ent-Main Campus/313-916-3272			

07:08 10/29/2011 by Mayura Phadtare, MD

Prescriptions:

Prescription		
Medication	**Dispense**	**Sig Line**
Motrin 800 mg Tab	#30	1 po 3-4 times a day prn pain
VICOdin ES 7.5 mg-750 mg Tab	#10	1 PO q4hrs prn pain

07:51 10/29/2011 by Mayura Phadtare, MD

Staff physician:

Teaching physician note: I personally saw and evaluated the patient. I was physically present for key portions of the services provided., I reviewed the resident's note and agree with the documented findings and plan of care without changes.
18:28 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

Chart electronically signed by Responsible Physician
18:29 11/06/2011 by Stephanie Stokes-Buzzelli, MD EM Staff

Henry Ford Health System **Operative Note**

Document State: Final (version 2)
Update Date/Time: 09/12/2012 10:49

Patient Name: **HALL, RICHARD L.**
DOB/Age/Gender: 11/11/1975 36y Male
Location: HF,HF Medical Center-Fairlane Operating Room

MRN: **HF 33680716**

Service Date/Time: 09/10/2012 00:00
Provider: MATTHEW M SMITH
Responsible Staff: LAMONT JONES MD

Anesthesia: General

PREPROCEDURE DIAGNOSIS: Recurrent tonsillitis

POSTPROCEDURE DIAGNOSIS: Recurrent tonsillitis

OPERATION: 1. Tonsillectomy.

SURGEON: Lamont Jones MD

ASSISTANT: Matthew Smith MD

ANESTHESIA: General

EBL: 5 ml

OPERATIVE FINDINGS: Patient had 2+ tonsils bilaterally which were equal in size.

INDICATION FOR PROCEDURE: Patient is a 36 year old male with history of recurrent tonsillitis and chronic tonsilliths who did not want to try conservative treatment and wanted his tonsils removed. He was discussed the risks and benefits of tonsillectomy and consented for the procedure.

DESCRIPTION OF PROCEDURE: After time out and under general endotracheal anesthesia, the self-retaining mouth gag was inserted, opened, and suspended on the Mayo stand. No submucous cleft palate was found on palpation.

Local anesthetic was then injected into the soft palate (10ml of 0.25% marcaine plain).

A curved Allis clamp was used to retract the right tonsil medially, and an incision along the anterior tonsillar pillar was made using electrocautery. Further dissection revealed the tonsillar capsule, and capsular dissection allowed for the complete excision of the right tonsil. Meticulous hemostasis was achieved using electrocautery. A similar procedure was completed on the left.

The mouth gag was relaxed briefly before being resuspended. The tonsillar fossae were gently abraded, and meticulous hemostasis was ensured bilaterally. An orogastric tube was passed into the stomach and suctioned out.

Then all equipment was removed and the patient was returned to anesthesia care. The patient was awoken, extubated, & returned to PACU in stable condition.

Attestation

I was present for the entire period between opening and closing of the procedure(s).

Signed by **LAMONT JONES MD** at **09/12/2012 10:49:21**.

Operative Note

Patient Name: **HALL, RICHARD L.** MRN: **HF 33680716**
DOB/Age/Gender: **11/11/1975 36y Male**
Location: **HF,HF Medical Center-Detroit Campus Clinic ENT/Audiology (K8)**

Document State: **Final** (version 2)
Update Date/Time: **02/13/2012 11:15**
Service Date/Time: **02/03/2012 11:16**
Provider: **WILLIAM YOUNG MD**
Responsible Staff: **LAMONT JONES MD**

Pre-Op Diagnoses:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Post-Op Diagnoses:

Anesthesia: General
Senior Staff Physician: JONES, LAMONT, MD
Resident: YOUNG, WILLIAM, MD

Preop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

Postop diagnosis:
1. nasal bone deformity s/p trauma
2. septal deviation
3. nasal obstruction
4. turbinate hypertrophy

procedure:
1. closed septorhinoplasty
2. bilateral inferior turbinate outfracture

Surgeon: Lamont Jones, MD
Resident Surgeon: Wm. Greg Young, MD

EBL 20ml

Findings: large left septal spur and deviation of the maxillary crest. C shaped deformity of the nasal bones with the right side concave and
the left convex.

Indications: Mr. Hall is a 36 year old male with a history of nasal trauma s/p assult with nasal bone fracture and septal deformity. He complained of nasal obstruction and a recommendation was made for closed rhinoplasty with osteotomies and septoplasty with inferior tubinate outfracture. Despite the risk of bleeding, infection, septal perforation, CSF leak, smell disturbance, continued nasal obstruction, need for further procedures, and the risk of anesthesia, the patient wished to proceed.

Description:
The patient was brought to the operating room by our anesthesia colleagues where she underwent general endotracheal anesthesia. Once an adequate plane of anesthesia was achieved, the patient was prepped and draped in the usual sterile fashion. The nose was packed with Afrin-soaked pledgets. The nose was also injected with total of 6 mL of 1% lidocaine, 1:100,000 epinephrine solution. After adequate time for vasoconstriction and anesthetic effect, examation of the anterior nose with the nasal speculum revealed a large left septal spur and maxillary crest prominence. A left sided hemitransfixion incision was made and a mucoperichondrial flap was elevated on the septum and a tunnel was also elevated along the nasal floor. The two tunnels were connected at the site of the left septal spur. The bony cartilagenous junction point was separated and the deviaed bone was taken down with the open Janson middleton forceps. The small piece of septal spur was also taken down after

being completely separated from the mucoperichondreal flap.

With the spur gone, the cartilage was seen to be deviated over to the left due to the prominent maxillary crest. The cartilage was separated from the maxillary crest by incising a small stip of cartilage from its inferior aspect.

A osteotome was used to take down the deviated portion of the nasal maxillary crest. Once taken down, the attention was directed towards the nasal bones. A small pocket in the piriform aperure skin was made. The lateral osteotomes were placed against the pyriform aperature just superior to the anterior insertion of the inferior turbinate. In a high low high fashion, the osteotome was advanced through the nasal bones, first on the left then the right. The nasal bones were mobilized and directed medially with good reduction.

The hemitransfixion and priform aperature incisions were then closed in an interupted fashion with 4-0 chromic suture. A quilting suture was placed across the nasal septum. There was only a a small rent at the site of the septal spur posteriorly, without any correspoding perforation on the opposite side of the septum.

The inferior turbinates were then outractured with good results.

The stomach was suctioned with a temporary orogastric tube.

Steri-Strips and an Aquaplast cast was then applied. Patient was then awakened and extubated without difficulty.

Attestation

I was present for the entire period between opening and closing of the procedure(s).

Signed by **LAMONT JONES MD** at **02/13/2012 11:15:55**.

TN 517272562
SCT03636335

WE FIGHT THE LAW, PLLC

ATTORNEYS AND COUNSELORS AT LAW

February 12, 2013

I suffered
Broken Ribs
+ Broken
Nasal

Richard Hall
6626 Hartford St.
Detroit, MI 48210

RE: POLICE INCIDENT OF OCTOBER 28, 2011

Dear Mr. Hall:

This will follow up the conversation of today's date you had with attorney Miller regarding the above referenced matter.

Allow me to begin by stating that we appreciate your understanding and patience in this matter. Litigation is a lengthy and time-consuming endeavor. Your particular litigation is even more so, due to the FOIA issues we had previously discussed; specifically the City of Detroit's inability to provide us with the requested FOIA materials in a timely manner. Growing frustrated and impatient with the lack of progress at this stage is understandable, and we certainly sympathize with you in this regard.

Having said this, your recent behavior and actions have become worrisome. Specifically, your persistent and continuous calling could be considered border-line harassment. Further, the subject of these calls, your requests for aid in obtaining loans, is troublesome as we have not yet filed suit.

We sent a FOIA request on June 26 and received a confirmation letter from the City of Detroit on July 18. On August 9, we received another letter, stating that no information could be found without more details. Upon learning that Sgt. Tonique Roche had investigated the incident, we renewed our request on October 17 with the new information. We received a confirmation letter on December 5, and following various emails, letters, and phone conversations, agreed to give the City more time to comply with our request due to their moving buildings. On February 7 we sent a second request and indicated that we were no longer willing to wait. As I had indicated to you in our phone conversation, we are preparing to compel them to provide us the requested documents. We are bound to provide a professional courtesy to the City, and certainly our agreement to provide them more time falls within that courtesy, but we are now taking the necessary steps to further your case. To be candid, Mr. Hall, we cannot proceed without these documents.

I need to make a few things perfectly clear, so I will be frank. You are not

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 SCT0363633S

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ATTORNEYS AND COUNSELORS AT LAW

our only client. Your litigation is not our most pressing concern at this time, due to our inability to act until we have received the documents we have requested through the FOIA process. There are cases which have deadlines and trials happening now. Expecting us to drop everything we are doing to help you get a $500 dollar loan when people's lives are depending on our actions is not only disrespectful to our firm, but insulting to us as individuals. When it is your time for trial, you will certainly appreciate our dedication to only you.

Having said this, please understand that your continuous calls need to stop. If you have an immediate need, new information, or an emergency, please know that we are here for you. However, calling our staff on their personal phones repeatedly on their off time is not acceptable. Please consider this a formal request to stop.

Finally, please be aware that your "case" does not yet exist. Depending on the information we are able to gather, we may not be able to help you any further, litigation may not be viable, or the amount of potential recovery may be significantly lower than you expect. With all of these factors, I feel I must advise that taking out loans against the possible outcome comes at a great personal risk to yourself Mr. Hall. I say this to you on a personal level, and not as a critique or statement as to the validity or merit of your case.

I hope that this has helped to clarify the situation, and if you have any questions or comments please feel free to call our office.

Sincerely,

WE FIGHT THE LAW, PLLC

Nicholas Keith

NICHOLAS JOSEPH KEITH
EXECUTIVE ADMINISTRATIVE COORDINATOR

NJK/njk

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